DECEMBER 2018

Virginia Behavioral Health Redesign

STAKEHOLDER REPORT

EUGENE S. FARLEY, JR. HEALTH POLICY CENTER
UNIVERSITY OF COLORADO ANSCHUTZ MEDICAL CAMPUS

VIRGINIA'S MEDICAID PROGRAM DMAS INNOVATION • QUALITY • VALUE

Virginia Department of Behavioral Health & Developmental Services

Acknowledgments

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About us

The Farley Health Policy Center strives to advance policy that overcomes fragmented systems and addresses the wholeness of a person – physical, behavioral, and social health in the context of family, community, and the healthcare system. The FHPC works with state agencies and policymakers to understand and inform achievable policy actions to improve the integration of behavioral health across health and healthcare systems.

Stephanie Kirchner, MSPH, RD

Emma Gilchrist, MPH

Stephanie Gold, MD

Shale Wong, MD, MSPH

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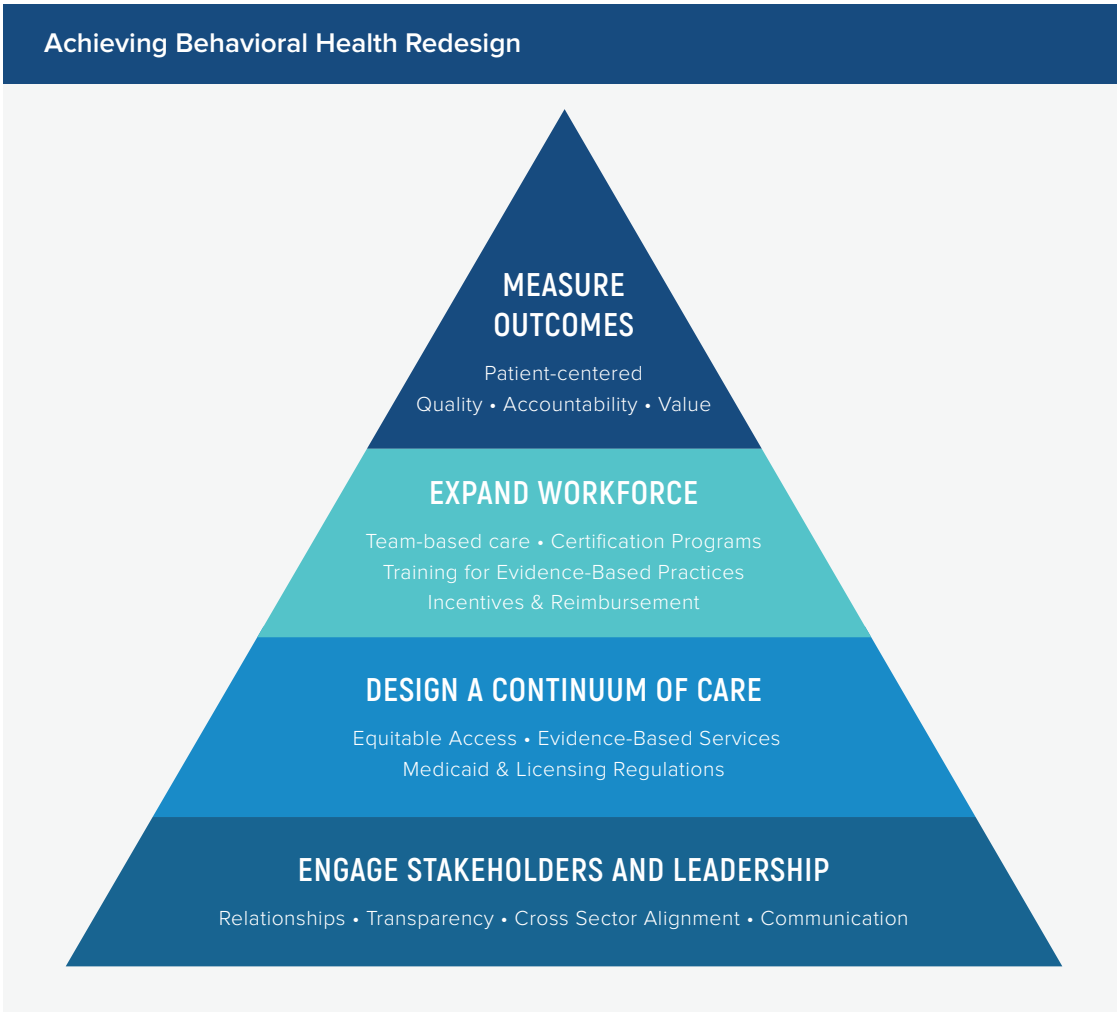
Introduction

The Virginia Department of Medical Assistance Services (DMAS) and the Virginia Department of Behavioral Health Developmental Services (DBHDS) recognize the vital role of engaging stakeholders to inform successful redesign of Medicaid-funded behavioral health services for the Commonwealth. Several preliminary efforts have been undertaken to encourage active engagement between the interagency team, additional state agencies and system stakeholders. The goals of these efforts have been to establish and maintain venues for open communication regarding behavioral health systems redesign; strengthen the collective, collaborative partnerships, which are central to the success of redesign; and share information on current work and intentions while planning for behavioral health redesign. The Farley Health Policy Center (FHPC) supported the agencies' stakeholder engagement process by participating in and planning Behavioral Health Redesign Workgroup meetings and leading the design and analysis of the stakeholder survey.



Findings from several months of stakeholder engagement work are described in this report, organized around broad areas of a continuum of behavioral health services: promotion, prevention, and early intervention; treatment; and recovery. Across these service areas, common themes emerged from stakeholder input including:

ACCESS

Respondents reported there are significant wait times for needed services and geographic variation in access. Transportation presents a common barrier to accessing services.

FUNDING

Respondents suggested raising reimbursement rates for services to increase workforce growth, noting that in some instances the costs of delivering a service are greater than the reimbursement. Some evidence-based practices are not currently reimbursed.

REGULATION

There is a need for aligning regulations across Managed Care Organizations and across agencies. Many respondents reported that current licensure requirements are burdensome and recommended lowering these; however, some respondents suggested more detailed credentialing of providers.

WORKFORCE

Workforce shortages are present across the domains of the continuum of care, particularly in rural areas. Provider types particularly in need include peer support service providers and psychiatrists. Low reimbursement rates were cited as a challenge in recruiting and retaining providers.

These themes are highly interrelated and the intersections between them are illustrated repeatedly in the feedback from Virginia stakeholders. In addition to feedback around these areas, stakeholders identified both the bright spots and the opportunities within service areas, and shared their hopes and concerns for the redesign process.

Virginia Behavioral Health Redesign Stakeholder Engagement Process

Stakeholder Kickoff Meeting

On July 24, 2018, the FHPC led a stakeholder kickoff meeting to introduce an overview of the opportunities ahead to offer input for informing the redesign of the continuum of behavioral health services for Medicaid members in Virginia, establish a forum for bidirectional communication, and introduce themselves to stakeholders. Appendix A identifies stakeholders engaged by DMAS and DBHDS for participation and input throughout this process, including members of the DMAS Behavioral Health Quality Collaborative.

Formation of the Behavioral Health Redesign Workgroup

The DMAS Behavioral Health Quality Collaborative was expanded to include a broader stakeholder group representative of behavioral health service delivery in Virginia. This stakeholder group, the Behavioral Health Redesign Workgroup (BHRW) met three times in October and November, 2018. The interagency team of DMAS and DBHDS extended invitations to the redesign workgroup considering:

1. inclusion of a broad range of groups deeply involved and invested in the behavioral health system in Virginia;
2. the need to bring together a group large enough to be representative, but not so large that it would prohibit meaningful discourse and participation in the planned, structured activities of the group and
3. pragmatic factors such as space considerations.

The workgroup invitation list was composed of representatives from provider organizations, Community Services Boards (CSBs), professional organizations (for specific disciplines), advocacy organizations who support Medicaid members (e.g. Voices for Virginia's Children, NAMI, etc.), managed care organizations (MCOs), hospital and healthcare organizations, and also other state agencies involved in relevant work. Each organization was allotted two representatives with the exception of the CSBs, who were granted five representatives, one representing each geographic region. The members of the workgroup were entrusted with the task of disseminating information communicated at the workgroup meetings back to those whom they represent.

The initial meeting BHRW meeting (10/2/18) provided an overview of the system drivers for redesign of the Medicaid-funded behavioral health system. Interagency team leaders facilitated a structured group exercise where participants considered the current array of Medicaid-funded behavioral health services and provided written comments on where they currently experience gaps and challenges in the delivery of these services in their work.

The second convening of the BHRW (10/23/18) included a review of the feedback gathered through the initial gap identification exercise to ensure that all feedback was integrated. Stakeholders participated in a second structured activity in small groups representing different service categories that exist in the current system (Prevention, Outpatient Services, Community Based Services, Residential and Inpatient). Interagency and FHPC leadership facilitated small group discussions of "bright spots" in the current Medicaid service-delivery system, encouraging stakeholders to identify what is currently working well. Prior to the workgroup, leadership devised and sent out a worksheet to members to prepare their comments for these discussions. Preparatory questions explored: 1) the unique or innovative aspects of the behavioral health service delivery system that are working well in Virginia; 2) evidence-based interventions or models that are working well; and 3) where the services their organization (or the organizations or providers they represent) fall within the Institute of Medicine (IOM)/Substance Abuse and Mental Health Services Association (SAMSHA) Continuum of Care. Notes from the discussion and the completed worksheets were analyzed by FHPC and incorporated into the qualitative findings presented in this report.

Stakeholder Survey

A web-based stakeholder survey was administered between 11/9/18 and 11/16/18 to collect perspectives on the development of a continuum of evidence-based, trauma-informed, and prevention focused Medicaid-funded behavioral health services. Stakeholders reviewed the current array of behavioral health services funded by Medicaid (Appendix B) and responded to questions addressing six areas:

1. if the current service array met the behavioral health needs in Virginia;
2. if their organization's services were included in the current service array;
3. if there were services that are duplicative or should be removed;
4. if there are access challenges with the services;
5. if there is a proficient workforce to provide the services; and
6. if the workforce had the appropriate licensure to meet the mental/behavioral health needs in Virginia.

The questions were repeated to ask about services in three domains of the IOM/SAMHSA continuum of care: promotion, prevention and early intervention; treatment; and recovery. This report presents the quantitative and qualitative findings from the survey In addition to demographics. (See Appendix C for agencies and organizations represented in the survey).

Presentation of Survey Results to Stakeholders

The third BHRW meeting (11/27/18) provided stakeholders with a preliminary overview of general themes identified from the survey. As described in the body of this report, these included access, workforce, funding and regulation both across the array of behavioral health services and identified hopes and concerns. Stakeholders provided verbal feedback that was recorded in notes from the meeting to be included in the final survey analysis.

Methods

A mixed methods analysis examining descriptive statistics and an editing analysis style was completed using data from three stakeholder engagement opportunities (gap exercise, bright spots exercise, stakeholder survey). An editing style of coding was used to generate codes as they emerged from the data. These codes were then segmented according to domains (sections of the service array) and analyzed for themes. The codes and themes were reviewed by the FHPC team for reliability and then summarized into the major thematic constructs within this report.

It is important to note that the following is an analysis reflecting responses from stakeholders. The intention of the BHRW and stakeholder survey was to collect broad input from representatives across the state. The stakeholder survey was disseminated to the BHRW and key partners, with the request that they forward to broaden dissemination, and was designed to collect input from one individual per organization, preferably someone in a leadership position with a systems-level perspective.

Survey questions were attached to the distribution email so that individuals completing the survey could gather input from colleagues before completing. When collecting stakeholder input, there is a risk that some information reported or shared comes from a place of misinformation of misinterpretation – meaning that what is reported may not always be accurate or founded. It remains vital to take all of what was shared into consideration, but not assume that everything can, or even should be, solved.

Results

Profile of Survey Respondents/Demographics

The stakeholder survey received 203 responses. The survey was structured into four sections: demographic information; promotion, prevention and early intervention; treatment; and recovery. Once the demographic questions were answered, respondents had the option to answer questions for each of the service areas, or to skip to the next section if that service area was not related to their work and expertise. Responses were included if any of the sections were completed; 163 respondents completed the full survey. Notably, the demographic information below only captures that of the individual survey respondent. Many respondents were collating feedback from others in their organization whose demographic information is not represented here.

OF THE 203 RESPONDENTS

75%	85%	11%	2%	1%
Female	Caucasian	Black/African American	Hispanic/Latino(a)	Other

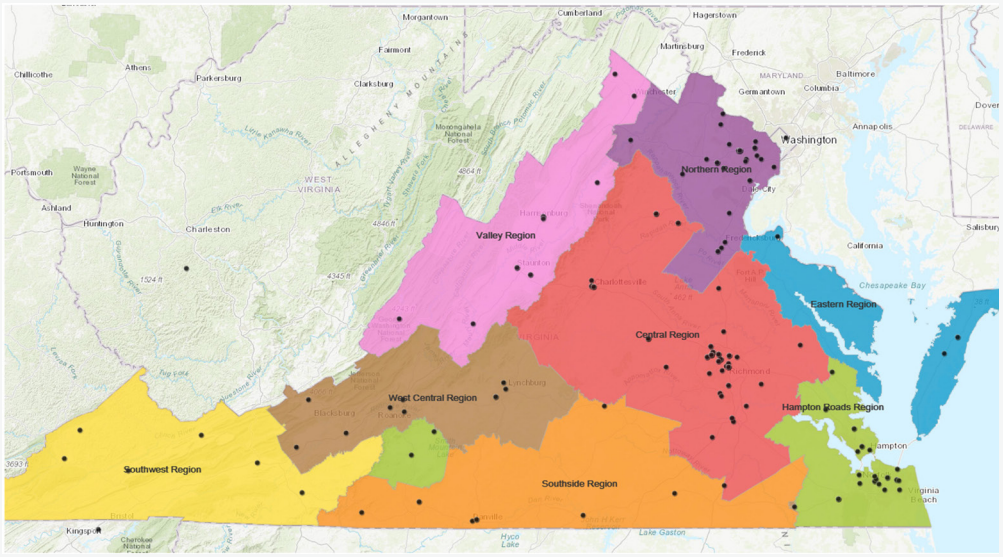
MAJORITY OF AGES RANGED ACROSS THREE CATEGORIES

27%	30%	28%
35-44 years old	45-55 years old	55-64 years old

The majority of respondents (69%) hold a Master's degree. Seventeen percent report holding a Bachelor's degree, 9% a doctoral degree, and 1% a medical degree. Two percent reported 'other', including partial completion of Bachelor's and doctoral degrees. Fifty-four percent are currently licensed as a mental or physical healthcare provider in Virginia.

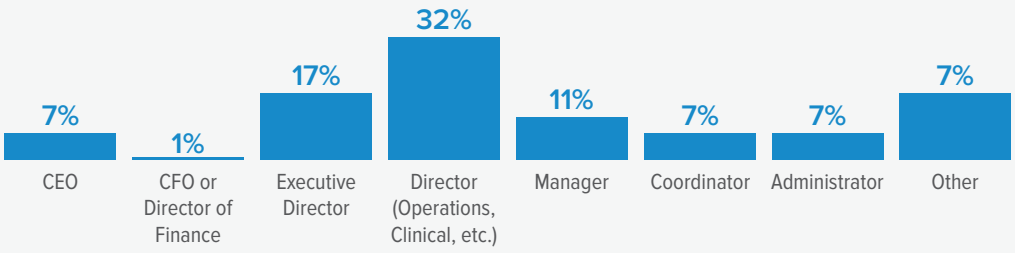
Zip code data reflects that stakeholders from across the Commonwealth are represented in the survey results, with some clustering around the greater Richmond area and in Northern Virginia. Responses are reflective of those who completed the survey, meaning that in some cases organizations that represent members across the state were answering based on location of their central office. Responses to questions about access, workforce and mental health services reflected consistent challenges across DMAS regions, except for mental health recovery. Stakeholders from the Hampton Roads, West Central, and Valley Regions were more likely to indicate there was not adequate enough workforce to provide mental health recovery services compared to stakeholders from other regions (>85% vs. <67%, respectively).

Figure 1. Distribution of survey respondents by region



Survey instructions requested that the survey be completed by a representative from each organization or agency, recommending that person be in a leadership role with a systems-level perspective. The current roles of survey respondents reflected this guidance: 32% were directors (clinical, operations, etc.) and 17% were executive directors (Figure 2). Seventeen respondents selected 'other'; their roles included clinician/therapists, other executive leadership roles, nurses, policy analysts, consultants/technical assistance providers, probation officers, and a teacher.

Figure 2. Current role/position



Survey respondents have established careers working in behavioral health, with 45% reporting they have been involved in behavioral health work for over 21 years (Figure 3). Most are relatively new to their current role; 54% report they have been in their current position for 5 years or less (Figure 4).

Figure 3. How many years have you been involved in behavioral health work?

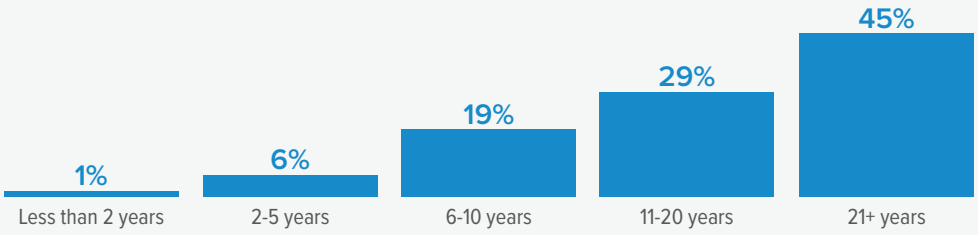
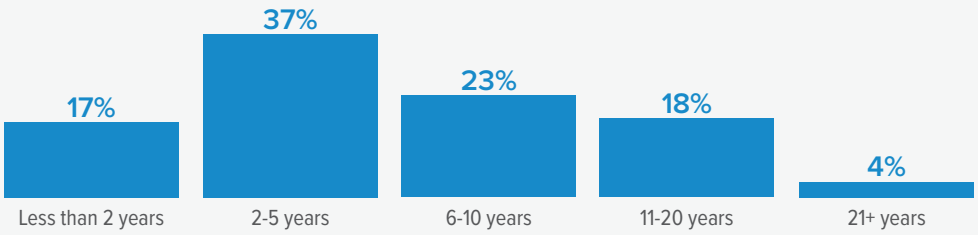
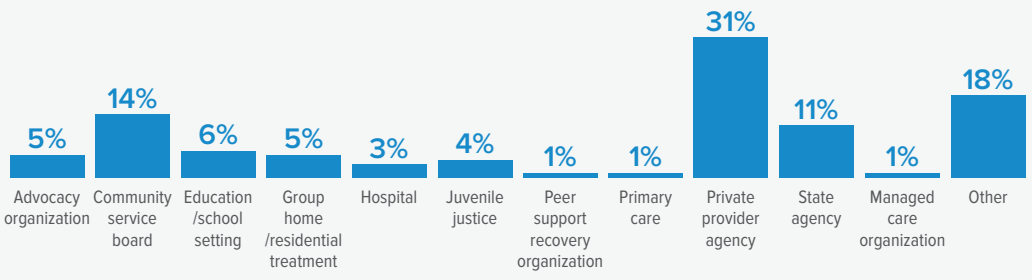


Figure 4. How many years have you been working in your current role/position?



Survey respondents were asked to identify the organization they represent. A full list of organization and agencies is included in Appendix C. Additionally, respondents were asked to categorize their employment setting. Thirty-one percent identified their primary employment setting as a private provider agency; 14% as a community service board; and 11% as a state agency (Figure 5). Eighteen percent indicated 'other' and categorized their primary employment settings as: local city or county agencies, community agencies, home visitation or in-home service providers, social service agencies, non-profits, or academic medical centers.

Figure 5. Primary employment settings of survey respondents.



Finally, respondents were asked about the primary behavioral health services their organization provides and the primary population their organization serves. Both questions allowed respondents to select all that apply. Sixty-nine percent report providing mental and behavioral health treatment (Figure 6). Thirty-five percent provide promotion and prevention services and 31% provide substance use treatment, while 18% report providing recovery services and 6% provide primary care services. Thirty-one percent selected 'other' and reported their organization is not a service provider, but coordinates or funds services; provides applied behavior analysis services; is an advocacy organization; an education organization; or provides intellectual and development disabilities services. The majority of respondents indicated they serve children (80%) or adolescents (75%) (Figure 7). Fifty-two percent reported serving adults and 20% reported serving older adults. Seventeen percent reported serving individuals across the lifespan: children, adolescents, adults, and older adults.

Figure 6. What are the primary behavioral health services your organization provides? (select all that apply)

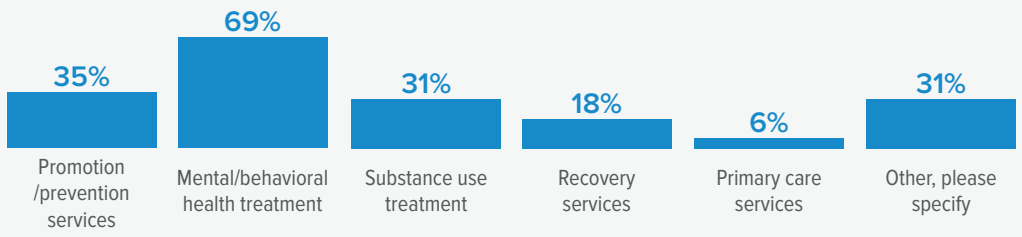
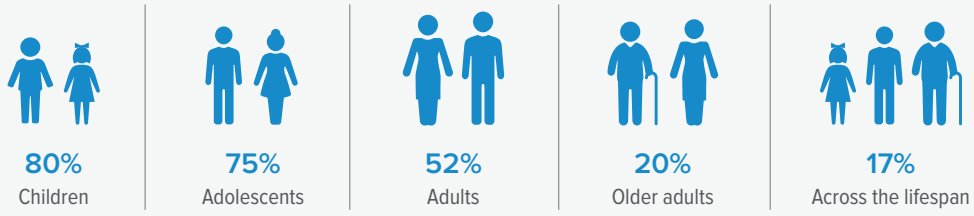


Figure 7. What are the primary populations your organization serves? (select all that apply)



Prevention, Promotion, and Early Intervention

Nearly half of respondents answered the Prevention and Promotion section, with 95 respondents answering every question in this section. Forty-seven percent reported the current array of Medicaid-funded prevention and promotion services do not meet the behavioral health needs in Virginia. Twenty-seven percent reported the prevention and promotion services that their organization provides are not reflected in the currently funded services.

KEY THEMES

WORKFORCE

Shortages in mental health workforce create a ripple effect across access to services. When asked about the workforce to provide prevention and promotion services, 57% indicated there are significant workforce challenges. Stakeholders reported a lack of qualified professionals to provide prevention, promotion, and early intervention services and an insufficient number of providers to meet prevention needs across a continuum of care. Stakeholders suggested more affordable training and education to enhance the skills of providers and changing reimbursement rates to create financial incentives to attract professionals to this area of service. Forty-two percent of respondents reported clinicians have the appropriate licensure to provide these services while 29% reported that licensure needs redesign or that there are licensure gaps in providing these services.

"Overall, more providers are needed to address disparities in access."

"Workforce across the system needs training to shake up thinking regarding prevention and early intervention."

"We need more social emotional and trauma informed care training for staff in early care and education settings, and training for staff who work with parents."

"The challenges are recruiting and retaining highly skilled and quality professionals. There is a high demand (for QMHPs), but without adequate funding to offer competitive pay, they are hard to find or retain."

ACCESS

Fifty-nine percent of respondents reported that the individuals they serve have challenges accessing the currently Medicaid-funded prevention, promotion and early intervention services. Access to behavioral health services and the qualified professionals that provide them are undeniably intertwined. Access to services across the state of Virginia are reportedly varied and wait times present barriers. Services available at CSBs are varied and inconsistent; within Managed Care Organizations (MCOs), services vary with differences in service requirements.

"It is not a matter of increasing the type of services offered, but the need to assure equitable service access regardless of locality."

"It can take months to get a first appointment at a time when families could be in chaos."

REGULATION

Alignment of regulation is essential to provision and funding of mental health service as it directly affects both workforce and access to services.

"Establish fluid cross-over in regulations for licensed professionals and licensed behavior analysts to provide service across populations, etc."

"Including Applied Behavior Analysis (ABA) services would significantly impact the amount of licensed providers capable of providing early intervention services at an intense level to help prevent the future need of series for individuals with Intellectual Disability (ID)/Developmental Delay (DD), specifically Autism Spectrum Disorder (ASD)."

FUNDING

Stakeholders reported low reimbursement rates for services to be a barrier to meeting needs. These include: early intervention case management; Applied Behavior Analysis; and inadequate state and federal funding for prevention services.

"Serving these children is critical as we know the earlier we can get the children with social/emotional and infant mental health concerns, the more likely we are able to intervene and stop a cycle of what could be lifelong issues that (as we all too often are seeing in the news) can be devastating for communities and our society."

KEY SERVICE BRIGHT SPOTS

- Early Intervention Part C
- Virginia Perinatal and Neonatal Collaborative
- Child Development Centers of Excellence
- Virginia Mental Health Access Program (funded by a Health Resources and Services Administration (HRSA) grant)
- Community Service Boards work for transitional age youth with first episode psychosis

KEY SERVICE NEEDS

General:

- Expanded screening and improved access to substance use early intervention
- Universal Screening Brief Intervention Referral to Treatment (SBIRT)
- Parent training/counseling

Children/adolescents:

- Early childhood home visitation
- More mental health providers in schools
- More licensed psychologists, licensed clinical social workers and licensed psychiatrists who serve young children
- Applied Behavior Analysis under Part C
- Services for children 3-5 years old, to fill the gap between Early Intervention Part C and school-based programs

Treatment

More respondents responded to the Treatment questions than to the Prevention and Promotion or Recovery service questions, with 63% answering every question within the treatment section. Thirty-six percent reported that the currently funded Medicaid services for behavioral health treatment do not meet the needs in Virginia; 38% reported that treatment services need redesign. Of the 38% reporting treatment services need redesign, 74% indicated services need both funding and practice redesign. Sixty-two percent of respondents identified the treatment services provided by their organization are in the service array while 13% stated their services were not within the service array. Sixty-three percent indicated that none of the services listed were duplicative or should be removed from the service array (31% reported they did not know or did not have enough information to respond).

KEY THEMES

WORKFORCE

As described in the prevention section of the service array, workforce shortages create barriers to providing treatment services. When asked about the workforce to provide treatment services, 75% of survey respondents reported there are significant workforce challenges. Fifty-two percent reported clinicians have the appropriate licensure to provide treatment services while 33% report licensure needs redesign or there are licensure gaps in providing these services. The reported concerns include recruiting and retaining qualified professionals in rural parts of the state, often citing compensation concerns. Many stakeholders emphasized the need for more psychiatrists and trained substance use providers. To address some of the workforce challenges, stakeholders suggested improving collaborations between state agencies and colleges/universities to train, educate, and provide applied learning opportunities for students interested and seeking employment in the behavioral health field.

"It can be hard to identify and obtain qualified individuals to perform the services in rural locations, making the ability to provide the services there difficult."

"We are in desperate need for more psychiatrists."

"Barriers to appropriate employment of peer recovery specialists consist of a lack of understanding the nature of peer services, as well as the state's extensive list of barrier crimes, which limits the ability of those with behavioral health challenges to be appropriately served with peer services."

ACCESS

Similar to prevention services, respondents report disparities in available treatment service across the state. Seventy-nine percent of respondents report the individuals they serve have challenges accessing the current Medicaid-funded service array for treatment services, the highest percentage out of promotion and prevention, treatment, or recovery services. Only 10% reported treatment services are available and accessible. Transportation is cited as a consistent barrier to access, especially in rural communities. The continued concern of lack of access to psychiatry services is expressed, tying directly back to workforce shortages. Integration of behavioral health with primary care is discussed as lacking, but also as a potential sustainable solution to improve access to behavioral health services. Stakeholders cite regional variation, problems with transition to Commonwealth Coordinated Care Plus (CCC+) and Medallion 4.0, and MCO pre-authorization approval delays as barriers to accessing treatment. Additionally, stakeholders identified a lack of services for mild to moderate behavioral health needs, as well as step-down community-based services for patients.

"Individuals with limited access to public transportation are not always able to access certain types of service providers resulting in limited ability to get the help they need. Also, individuals who are symptomatic, homeless, or are difficult to engage, may not always access these services through the more traditional channels. Individuals with severe and persistent mental illnesses and co-occurring medical conditions are often particularly challenged in accessing more specialized services if they do not have personal or social supports to assist them in doing so."

"All localities are not created equal."

"Children's psychiatric serves are hard to find and get quick access to. There are often waiting lists for many services when children and families are at their most critical moments."

"The CSB's need to not be considered the sole access point to the publicly funded behavioral healthcare system."

REGULATION

Recommendations to revisit licensure restrictions and regulatory burden are repeatedly expressed. Who is licensed to provide what services appears to create confusion and impact access. Some stakeholders caution that changing regulations, particularly in regard to the Qualified Mental Health Professional (QMHP) requirements, make it increasingly hard for agencies to recruit and retain qualified staff. Stakeholders report concerns about changing regulations and the implementation of Medallion 4.0, leading to inconsistent service denials by the MCOs. Stakeholders indicate conflicting opinions on licensure and credentialing: some suggest DMAS relax Medicaid regulations for licensed providers, allowing respective boards to monitor, while others state that more delineated credentialing is needed for evidence-based programs and designations such as Licensed Clinical Social Worker and Licensed Professional Counselor are not sufficient.

"Reduce regulatory overload."

"The continued increase in DBHDS and DMAS regulations requiring licensed individuals has caused a dearth of available licensed professionals across the state. Re-evaluation of the need vs. value added to have licensed clinicians in specific roles, i.e. creating treatment plans, performing assessments, etc. These tasks were done by well-trained professionals "Bachelor's degree and above" up until a few years ago."

FUNDING:

Reimbursement for evidence-based treatment services arises as a need for redesign. Respondents express that costs of services have increased as reimbursement rates have remained the same. Suggestions for redesign include permitting partial hour billing, increasing rates for higher quality services, and funding for team-based care. Specific services highlighted for funding redesign include assessments, Medicaid funding for housing as a mental health intervention, services provided by ABAs and LABAs, peer support services, and enhanced rates in rural areas.

"Provision of services costs providers more than they are reimbursed."

"Therapies that are evidence-based are not all reimbursed by Medicaid, but are recommended therapies in practice."

"Need to allow Primary Care Provider (PCPs) to deliver mental services and prescribe psychopharmacologic medications. This is not really a licensure issue, but a payment issue as some PCPs are not being allowed to prescribe antipsychotics, for a refill usually, because they are not licensed mental health providers."

KEY SERVICE BRIGHT SPOTS

- High-fidelity wrap around services (stakeholders also identified a need to expand this key service)
- Program of Assertive Community Treatment (PACT) teams (stakeholders also identified a need to expand this key service)
- Department of Juvenile Justice/Community Service Board collaborations
- Peer support (stakeholders also identified a need to expand this key service)
- Medicaid Addiction and Recovery Treatment Services Benefit (ARTS)
- Telepsychiatry (stakeholders also identified a need to expand this key service)

KEY SERVICE NEEDS

- Intensive Care Coordination
- 1 to 1 Services for residential treatment
- Therapeutic Monitoring
- Substance Use Disorder (SUD) treatment for teens
- Behavioral health services for transition age youth
- Services across treatment service array for youth
- Crisis stabilization for adults

Recovery

Twenty-seven percent of survey respondents answered questions on recovery services. Forty-three percent reported the currently funded recovery services do not meet the behavioral health needs in Virginia. About half reported the recovery services their organization delivers are included in the service array and over a quarter indicated their recovery services were not included. Eight-nine percent reported that none of the services listed were duplicative or should be removed from the service array.

KEY THEMES

WORKFORCE

Fifty-two percent of respondents reported there are significant workforce challenges to providing recovery services. Forty-four percent reported clinicians have the appropriate licensure to provide treatment services while 32% did not know or have enough information to respond to the question. Inadequate workforce to address recovery needs is due to similar challenges as reported in prevention/promotion/early intervention and treatment sections, with specific attention within recovery services to the lack of qualified peer support specialists and family support partners. Stakeholders recommend funding for peer support training programs or increased rates of reimbursement to facilitate workforce development, as "recruitment of peers and family support partners is difficult and underfunded."

"Peer supports are in short supply all across the state. Increasing the reimbursement rate for peer support would greatly help to expand the availability (of recovery services). We should also develop peer-operated respite and crisis services."

ACCESS

When asked about access to the currently Medicaid-funded recovery services, 76% of respondents reported the individuals they serve have challenges accessing recovery services, either due to services not being uniformly available or because there are consistently access problems. Access to recovery services across the state varies, with transportation again cited as a big concern, especially in rural areas. Services unique to recovery, such as access to peer and family support are repeatedly mentioned. Stakeholders report that peer support and family support partners should be tied to evidence-based practices; "otherwise, it is a nice service that is helpful, but it is difficult to show evidence of outcomes."

"We have no recovery services in our community. CSB is the only organization providing any service, and they do not have the capacity to serve all who are in need."

REGULATION

Stakeholders report the need for DMAS and DBHDS to align regulations for qualified peer providers. Input on supervision requirements for peers varied, with some stating the requirement of licensed providers to supervise should be revisited while others state more oversight is needed. Stakeholders reported the burden of the peer support certification process, including the lack of organizations and agencies where the required 500-hour work/volunteer requirement can be completed, is a barrier to increasing the workforce.

"DBHDS and DMAS regulations for qualified peer providers need to be aligned."

"The requirement for peers to be supervised by a licensed staff member flies in the face of what peers do. That is to say, they are working based on lived experience. The Licensed Mental Health Practitioner adds no value."

FUNDING

Stakeholders expressed the needed for increasing reimbursement rates for peer support services, and that funding redesign should consider recovery services as part of an integrated service approach. Funding permanent supportive housing as part of the service array would contribute to improved health outcomes and cost savings.

"Need to redesign rate structure and regulations for peer services."

KEY SERVICE BRIGHT SPOTS

- ARTS
- High-fidelity wrap around services (stakeholders also identified a need to expand this key service)
- Peer support (stakeholders also identified a need to expand this key service)

KEY SERVICE NEEDS

- Peer supports for individuals with substance use disorder
- Family Support Partners as part of evidence-based practices, like high fidelity wraparound services

Hopes and Concerns for Behavioral Health Redesign

Hopes and concerns articulated by stakeholders largely followed the same overarching themes related to access, funding allocation, workforce and regulation. Stakeholders express the need for leadership from state regulatory agencies, but also fear that their needs may not be ultimately met or continuously considered. Gratitude for the stakeholder engagement process is repeatedly conveyed, as is a request for this type of engagement to continue. The call for innovation and openness to change is also widely reported and a hope that Virginia can strategically execute a plan that reconsiders service options that were once available but no longer serve the needs of Medicaid members. Stakeholders report a sense of increased community awareness of mental health issues in Virginia, stated as an, "awakening amongst providers for the need to collaborate to improve outcomes," and the need to continue to unify and support this message moving forward.

HOPES

"It will stop the revolving door happening when people are hospitalized and released repeatedly."

"That quality services will be available in every part of Virginia and that youth and families will be able to access those services in matter their zip code."

"Communication and support from regulatory agencies."

"The increased use of evidence-based practices will improve consistency and accountability of services."

"Services in behavioral health are more person-centered and less administratively focused."

"Flexible, creative funding strategies, allowing providers to provide services."

"Virginia will take a systems approach to training mental health professionals in evidence-based practices."

CONCERNS

"Multiple regulatory agencies do not communicate changes to regulations effectively, and all have different expectations of providers, making it difficult to follow a universally accepted model of compliance."

"Changes will add more work for providers without a rate increase."

"Shrinking workforce to provide behavioral health services with increased credentialing requirements."

"Decreased access to services for low income families."

"Experience of rural communities in seeking behavioral health services is not fully understood by those developing policy in Richmond."

Conclusion

Across the continuum of behavioral health services from prevention, promotion, and early intervention, to treatment and recovery, stakeholders reported similar opportunities for redesign centered around workforce, access, regulation, and funding. These opportunities are all interrelated: aligning regulations around licensure and increasing reimbursement for services will support workforce growth, which in turn increases Virginians' access to the behavioral health services they need. Funding additional evidence-based practices across the continuum of care will also increase access to a broader spectrum of care, particularly lower acuity services.

> Stakeholders identified bright spots throughout the current continuum of behavioral health services, including System Transformation Excellence and Performance (STEP-VA) and the ARTS benefit. For many of the highlighted bright spots, stakeholders noted opportunities for further support to expand access to those services.

The stakeholder feedback from this report is being used to inform the final continuum of behavioral health services under Medicaid redesign. Stakeholder's views of what areas require redesign, bright spots, key service needs, and hopes and concerns will all be incorporated into both the redesigned services and also the ongoing planning process to ensure their voices are heard.

Some limitations were introduced across the effort to engage stakeholders in developing a continuum of mental health services in Virginia. As engagement strategies were initiated, gaps in representation were acknowledged, and essential stakeholders were continuously added to the process to best inform development of the continuum. Demographics represent only the individuals who entered data into the survey instrument or provided feedback on behalf of those they represent and consulted subject matter experts. As work moves forward in Virginia, the voices of additional groups, including potentially patients and consumers, should be considered to insure the best results across the state. In particular, with the stakeholder survey process, distribution was guided by the need to reach broadly while maintaining the ability to obtain feedback rapidly to inform preliminary redesign planning for the short-term. Next steps may include an effort to expand the perspectives represented to support both buy-in and sustainability.

Importantly, the stakeholder feedback gathered also underscores the need for redesign in general. A majority of stakeholders reported for each service area that behavioral health services either do not currently meet needs or would require redesign to meet needs.

> Stakeholders have demonstrated their commitment to participate with valuable contributions to the process of redesign and share the hopes of the involved agencies that the work will lead to quality, evidence-based behavioral health services available to all Virginians.

Appendix A. Behavioral Health Redesign Workgroup Members

Thank you to the stakeholders in Virginia for their ongoing participation and commitment to behavioral health redesign in the Commonwealth.

Virginia Department of Medical Assistance Services

Dr. Alyssa Ward
Karen Kimsey
Ann Bevan
Dr. Kate Neuhausen
Ashley Harrell
Tammy Whitlock
Brian Campbell
Dan Plain
Jason Rachel
Rebecca Anderson

Virginia Department of Behavioral Health Developmental Services

Dr. Alexis Aplasca
Mira Signer
Holly Mortlock
Stacy Gill
Nina Marino
Dr. Dev Nair
Jae Benz

Office of Children's Services

Scott Reiner
Zandra Relaford

Virginia Department of Social Services

Elizabeth Lee
Carl Ayers

Virginia Department of Health

Dr. Norman Oliver
Cornelia Deagle
Shannon Pursell

Department of Juvenile Justice

Andrew Block
Beth Stinnett

Department of Education

Maribel Saimre
Amy Edwards
Martha Montgomery

Virginia Department of Health Professions

David Brown

Caliber Virginia

Jonathan Coleman
Christie Hartman
Teshana Gibson

Early Impact

Laurel Aparacio

Virginia Network of Private Providers

Jennifer Fidura
John Morris

Virginia Association of Behavior Analysts

Christy Evanko

Christine Holland

Virginia Association of Community Service Boards

Jennifer M. Faison

Sandy O'Dell

Debbie Burcham

David Coe

Margaret Graham

Ellen Harrison

Virginia Association of Community Based Providers

Mike Carlin

John Salay

Sean Blair

Virginia Coalition of Private Provider Associations

Bill Ellwood

Michael Triggs

Virginia Community Healthcare Association

Neal Graham

Heather Stone

Virginia Hospital and Healthcare Association

Jennifer Wicker

Alison Land

Bill Wasserman

Psychiatric Society of Virginia

Dr. John Urbach

James Pickral

VA Academy of Clinical Psychologists

Bruce Keeney

Dr. Treven Pickett

American Academy of Pediatrics-VA

Dr. Sandy Chung

Medical Society of Virginia

Melina Davis

James Dudley

Ralston King

National Association of Social Workers – Virginia Chapter

Debra Riggs

Virginia Council of Nurse Practitioners

Richard Grossman

Aetna

Harry Keener

Dr. S. Yaratha

Anthem

Dr. Les Saltzberg

Dr. Michael Shepherd

Magellan Complete Care

Danette Brady

Dr. Lisa Price-Stevens

Optima

Dr. Peggy Ebinger

Amanda Becker

United Healthcare

Karen Freis

Dr. Steven Dixon

Virginia Premier
Dr. Cleopatra Booker
Dr. John Johnson

Magellan of Virginia
Jessica Vermont

Voices for Virginia's Children
Margaret Nimmo Holland
Ashley Everette

VOCAL
Deidre Johnson

Mental Health America – Virginia
Bruce Cruser
Anna Mendez

Autism Society of Central Virginia
Bradford Hulcher

NAMI
Rhonda Thissen

FFPA Implementation
Dr. Sunny Shin
Dr. Lisa Jobe-Shields

Appendix B. Medicaid-funded mental/behavioral health services

Companion document to the stakeholder survey. Below is a list of the services that are currently reimbursed through Medicaid funding.

Promotion/Prevention/ Early Intervention Services	Behavioral Health Screening Early Intervention Part C EPSDT Early Childhood Services	Screening, Brief Intervention and Referral to Treatment (SBIRT)
Treatment Services		
Case management	GAP Case Management MH Case Management	Treatment Foster Care Case Management
Outpatient Services	Psychological Testing Individual Outpatient Psychotherapy Group Therapy	Family Therapy Psychiatric Services Primary Care Services EPSDT Personal Care Services
Inpatient Services	Hospital Evaluation/ Management Inpatient Hospitalization Psychiatric Residential Treatment	Therapeutic Group Home EPSDT Services: Residential, Group Home, 1:1
Community Mental Health	Psychosocial Rehabilitation Therapeutic Day Treatment Mental Health Skill Building Intensive Community Treatment Intensive In Home Crisis Intervention Crisis Stabilization Day Treatment / Partial	Hospitalization Behavioral Therapy Regional Educational Assessment Crisis Response and Habilitation (REACH) Services PACT Services Psychosocial Rehabilitation
Recovery Services	Mental Health Peer Supports	Family Support Partners

Appendix C. Agency and organizations represented in the survey

16th Court Service Unit

2nd District Court Service Unit

6th District Court Service Unit, Virginia Department of Juvenile Justice

Accomack County Department of Social Services

AES

Applied Behavior Consulting

Augusta Health

BASICS ABA Therapy

Behavioral Momentum

Braley & Thompson

Brook Road Academy at Saint Joseph's Villa

Building Blocks

Centra - Rivermont Autism Program

Centra Health

Central Virginia Health Services

Chatterbox Speech and Language Therapy, LLC

Chesapeake Integrated Behavioral Healthcare

Chesterfield Community Services Board

Childhelp, Inc.

Children's Hospital of the King's Daughters

Children's Services Act

Children's Services of Virginia, Inc.

Children's Trust Roanoke Valley

CHIP of SHR, (Children's Health Investment Program of South Hampton Roads)

Colonial Behavioral Health

Community Residences - CRi

Community Services Board Adult Services Discharge Planning

Compass Counseling Services of NOVA

Comprehensive Autism Partnership

Comprehensive Early Autism Services

CPB Behavioral Therapy and Advocacy Services, LLC

Crossroads Counseling Centers, Inc.

CSA

CSB

Culpeper County Dept of Social Services

Culpeper Human Services

Danville Social Services/CSA Program

Department Juvenile Justice

Department of Health

Department of Juvenile Justice, 30th District Court Service Unit

Department of Juvenile Justice, Juvenile Probation

Department of Social Services

Department of Social Services - Children's Services Administration

DePaul Community Resources

Dept. of Juvenile Justice

Dickenson County Behavioral Health Services

Dinwiddie County Dept. of Children's Services

District 19 Community Services Board - Child and Adolescent Services Division

District 19 CSB

Dominion Youth Services

Dooley School at St. Joseph's Villa

Early Impact Virginia/Families Forward Virginia

Elk Hill

Elk Hill Farm, Inc.

Embrace Foster Care LLC

Fairfax County Department of Family Services, Child Abuse & Neglect Prevention Services

Fairfax County Health Department

Fairfax-Falls Church Children's Services Act Program, Fairfax County Dept of Family Services

Fairfax/Falls Church Community Service Board

Families Forward

Families Forward Virginia - Prevention Services

Family Insight

Family Preservation Services, Inc.

Franklin City Department of Social Services

Friends 4 Recovery

Gateway Adaptive Services

Global Behavior Therapy Associates

Goochland County Public Schools

Grafton Integrated Health Network

Hallmark Youthcare

Hampton Department of Social Services

Hanover County - CSA

Harbor Point Behavioral Health Center

Harrisonburg Rockingham Community Services Board

HMDSS

HopeTree

HopeTree Family Services Treatment Foster Care

Horizon Behavioral Health

Inova Behavioral Health

Inova Kellar Center

INOVA Kellar Center PHP and IOP

Intercept Youth Services, ABA Services

Jackson-Feild Behavioral Health Services

King George County Public Schools

Liberty Point Behavioral Healthcare

LIFES Academy

Lifeworks Outreach Services, Inc. dba Family Teamwork, Inc.

McNulty Center for Children and Families of the Harrisonburg-Rockingham CSB

Mea'Alofa Autism Support Center

Mental Health America of Virginia

Middle Peninsula Northern Neck Community Services Board

Montgomery County Human Services

Mount Rogers Community Services Board

Multicultural Clinical Center

NAMI Virginia

National Counseling Group

Navigation Behavioral Consulting

Newport News Department of Human Services

Next Steps Behavioral Centers

Northern Virginia Applied Behavior Analysis, L.L.C., and George Mason University

Northern Virginia Instructional Consulting, LLC

Northwestern Community Services Board

Office of Children's Services

On Our Own Charlottesville

Optima Health

Partner for Mental Health

Pathway Homes Inc

Phillips ABA Therapy, LLC

PHILLIPS Family Partners

Pimmit

Positive Support for Children with Autism

Powhatan Department of Social Services

Premier Therapeutic Foster Care, Inc., Premier Family Counseling Center, Inc.

Pressley Ridge

Prince Edward County

Prince William Community Services

Prince William Community Services Board - Adult MH Services

Prince William County Community Services

Principled Behavior Consultants LLC

Private practice/ no Agency

PWC CSB

Rappahannock Area Community Services Board

ReadyKids

Recognizing Children's Gifts Behavioral Health Network

Richmond Department of Social Services

River City Comprehensive Counseling Services

Russell County Children's Services Office (CSA)/Department of Social Services

Snowflakes ABA, LLC

Social Services

Southside CSB

Specialized Youth Services of Virginia

Spectrum Transformation Group

St. Joseph's Villa

St. Joseph's Villa - Sarah Dooley Center for Autism

Strategic Therapy Associates

The Faison Center, Behavioral Health Clinic

The Hughes Center

The Madeline Centre, Inc.

The Up Center

Therapeutic Alliance

Timber Ridge School

UMFS

United Methodist Family Services

Universal Health System-First Home Care

University of Virginia, Dept of Psychiatry

Valley Community Services Board

Valley CSB

Virginia Beach Department of Human Services / Community Services Board

Virginia Chapter of the American Academy of Pediatrics

Virginia Commonwealth University Partnership for People with Disabilities Early Childhood Mental Health Virginia Initiative

Virginia Council of Nurse Practitioners

Virginia Department of Education, Office of Student Services

Virginia Department of Health

Virginia Department of Health Western Tidewater Health District

Virginia Department of Health/Eastern Shore Health District

Virginia Department of Juvenile Justice / Central Administration

Virginia Department of Juvenile Justice - Community Programs Division

Virginia Department of Social Services - Division of Family Services

Virginia Department of Social Services - Head Start Collaboration Office

VOCAL, Virginia Organization of Consumers Asserting Leadership

Voices for Virginia's Children

WeCare, Inc.

York Poquoson DSS

York Poquoson DSS-CSA program

Youth Solutions, Inc. dba Infinity Counseling Group

**Some respondents chose not to identify the organization/agency they represent*